of these patients (*4*). Among the 53 patients for whom individual data were available, AZV was given to 39 patients, Pfizer-BioNTech vaccine to 9 patients, and Johnson & Johnson vaccine to 2 patients.

For the Shao et al. report (*1*), we wondered why the oldest healthcare worker was 86 years of age. Also missing were the specific treatment and outcome of the patient with SCoVaG.

Available data suggest that SCoVaG is a rare complication of SARS-CoV-2 vaccination, irrespective of the vaccine brand used. SCoVaG should be diagnosed early so treatment can be initiated promptly. Whether the beneficial effect of SARS-CoV-2 vaccination outweighs the risk for adverse events (e.g., Guillain-Barré syndrome) remains a matter of discussion (*5*).

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SARS-CoV-2 Cross-Reactivity in Prepandemic Serum from Rural Malaria-Infected Persons, Cambodia

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To the Editor: We read with interest the observations by Manning et al. (*1*) that serum collected from malaria-infected persons in Cambodia before the coronavirus disease (COVID-19) pandemic harbored seroreactivity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) antigens but lacked neutralizing activity. These results suggest that malaria exposure may increase background reactivity in SARS-CoV-2 serosurveys and more specific measures of exposure, such as surrogate virus neutralization tests (sVNTs), may be necessary to capture functional SARS-CoV-2 seroreactivity in malaria-endemic areas. Additional studies in settings with distinct malaria transmission intensities would generalize and strengthen these findings.

One hypothesis for the unexpectedly moderate burden of SARS-CoV-2 in malaria-endemic countries in Africa is that exposure to *Plasmodium falciparum* confers functional protection against COVID-19 through cross-reactivity or general immune activation. To test this hypothesis, we analyzed 237 dried blood spot samples taken in January 2020 (prepandemic) from *P. falciparum*–exposed persons in a high-transmission setting in western Kenya for the presence of SARS-CoV-2 neutralizing antibodies (nAbs) using the GenScript SARS-CoV2 sVNT assay (https://www.genscript.com). Monthly *P. falciparum* real-time PCR results were collected in a previous study (*2*) for 138/237 persons in the 12 months prior to January 2020. Of these, 131 (95%) were infected with *P. falciparum* at least 1 time in 2019, suggesting that most persons included in this screening had been recently exposed to malaria parasites.

Consistent with findings in Manning et al. (*1*), none of the 237 people harbored SARS-CoV-2 nAbs, despite high prior levels of exposure to *P. falciparum*. Although nAbs are subject to decay after infection (*3*), this lack of nAb activity suggests that sVNTs offer a more specific measure of SARS-CoV-2 exposure than standard ELISAs (*4*). We further suggest that, given that protection from SARS-CoV-2 infection may be associated with the presence of nAbs (*5*), their absence in samples from both the Manning et al. study

(*1*) and our study does not support the notion that *P. falciparum* infections elicit functional humoral responses against COVID-19.

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Melioidosis in Children, Brazil, 1989–2019

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To the Editor: We read with great interest the article by Lima et al. (*1*), in which the authors have discussed 20 confirmed or suspected melioidosis cases in children over a period of 30 years, concluding that childhood melioidosis is more severe in Brazil. This conclusion seems far-fetched based on findings described in the article, although the authors state that the high death rate and clinical severity might have been attributed to underreporting of mild cases,

Melioidosis is not a notifiable disease in India. Even so, from a single tertiary-care teaching hospital at Odisha, we have reported >100 cases of culture-confirmed cases during 2016–2021 (*2*–*4*), of which 10 cases were in the pediatric population (8 cases of superficial pyogenic infections in otherwise healthy children and 2 cases of septicemic melioidosis). All case-patients survived except 1 of the 2 with septicemic melioidosis, an 11-year-old boy who had systemic lupus erythematosus and died despite adequate intensive therapy. The second septicemic case was a 3-year-old girl with underlying acute lymphoblastic leukemia; she was treated with intravenous meropenem for 10 days and was discharged with a regimen of oral cotrimoxazole for 12 weeks.

Clinical severity of melioidosis is predominantly a function of host immunity (*5*). At a more pragmatic level, we would like to emphasize that, in melioidosis-endemic regions, most immunocompetent children with melioidosis experience localized infections and have better clinical outcomes, whereas in children with risk factors such as immunosuppression and childhood malignancies, the clinical course may be sudden and severe. In our view, frequent environmental exposures may not entirely explain the severity of childhood melioidosis. Lima et al. should have provided additional evidence to support their conclusion that childhood melioidosis is more severe in the population in Brazil.

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Dr. Behera is an additional professor in the department of microbiology at All India Institute of Medical Sciences, Bhubaneswar, India. Her primary research interests are melioidosis, rickettsial diseases, and antimicrobial resistance.

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